Case No. 12-55995

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MICHAEL N. JONES, JILL JONES, AND G.J.,

Plaintiffs–Appellees,

v.

CLAUDIA WANG,

Defendant–Appellant

Appeal from the United States District Court of the Central District of California,
Case 2:11-cv-02851-SJO-VBK; Honorable S. James Otero

Motion for Leave to File Amici Curiae Brief in Support of the Petition for Panel Rehearing and Rehearing En Banc by The American Academy of Pediatrics, The American Professional Society on the Abuse of Children, The California Medical Association, and The Ray E. Helfer Society

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Motion for Leave to File an Amici Curiae Brief

Amici request leave of this court to file the accompanying amici curiae brief. FRAP 29(b); 9th Cir. R. 29–2(b).

I. Interest of Amici Curiae

Amici are the American Academy of Pediatrics, the American Professional Society on the Abuse of Children, the California Medical Association and the Ray E. Helfer Society. Amici are organizations of physicians and other professionals whose work includes treating, evaluating and reporting injuries caused by child abuse, and protecting children from further abuse.

Amici are concerned about this case because they believe the majority opinion will negatively impact a physician's ability to treat, evaluate and protect vulnerable victims of child abuse. Amici's individual organizations and interests are described more fully in the Statement of Interest in the attached brief and incorporated here.

II. Desirability and Relevancy of Amici Curiae Brief

This court has never before addressed a physician's authority to hospitalize a child in a case of suspected child abuse or considered immunity in that context.

Amici can provide the court with unique insight into the problems faced by physicians when they suspect a patient is being abused by a parent. Physicians,

and the hospitals in which they practice, face different challenges and considerations which are not faced by police or social workers in such situations.

In their brief, amici explain among other things how the majority opinion will require a doctor to violate medical ethics and best practices in child abuse cases, and have a chilling effect on the evaluation and reporting of child abuse.

III. Attempt to Seek Consent to File Amici Curiae Brief

Amici requested consent of all parties to submit its brief. 9th Cir. R. 29–3. Defendant-Appellant Dr. Claudia Wang consented. But Plaintiffs-Appellees, Michael N. Jones, Jill Jones and G.J. did not. In response to amici's request to file a brief, their counsel said, "We do not believe that amicus briefs are appropriate at this junction, and decline to consent to the filing of the brief."

Conclusion

Because this court is facing an issue of first impression involving physicians and immunity in the context of child abuse cases, amici request permission to file the attached brief so that they can present the viewpoint of physicians, hospitals, and child-abuse prevention organizations for this court's consideration.

Respectfully submitted,

s/ Audra Ibarra

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Statement of Corporate Disclosure

None of the amici curiae represented in this brief has a parent corporation or a publicly held company which owns 10% or more of its stock. FRAP 26.1.

Statement of Authorship and Funding

No part of this brief was written by counsel for another party in this case, nor was the brief funded by another party or its counsel. The Regents of the University of California funded this brief, and employ Dr. Claudia Wang at its UCLA Medical Center. FRAP 29(c)(5).

Statement of Interest

The American Academy of Pediatrics (AAP) is an organization of 64,000 primary care pediatricians, pediatric sub-specialists, and pediatric surgical specialists dedicated to the health and well-being of all infants, children, adolescents, and young adults. Through policy, education and advocacy, the AAP works to protect children from child abuse.

The American Professional Society on the Abuse of Children (APSAC) is one of the leading national organization for professionals who serve children and families affected by child maltreatment, which includes both abuse and neglect. As a multidisciplinary group of professionals, APSAC achieves its mission in a number of ways—most notably through expert training and educational activities, policy leadership and collaboration, and consultation that emphasizes theoretically sound, evidence-based principles. APSAC is a 27-year-old organization that has played a central role in developing professional guidelines addressing child maltreatment and, as such, is well qualified to inform the court about the nature of child maltreatment and the ways society acts to prevent it. APSAC is submitting this brief to assist the court in understanding the perspectives of professionals who are legally charged with and morally obligated to protect the safety and well-being of children who may have been abused or neglected.

The California Medical Association (CMA) is a not-for-profit, incorporated professional association for physicians with more than 40,000 members. CMA physician members practice medicine in all specialties and modes of practice throughout California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA and its physician members are committed to the protection of the physician's ability to exercise their medical judgment to provide quality and effective care for their patients.

The Ray E. Helfer Society, founded in 1999, is an honorary society of physicians seeking to provide leadership to enhance the prevention, diagnosis, and treatment of child abuse and neglect. The purpose of the Helfer Society is to promote education and training in the medical aspect of child abuse and neglect; to advocate for improved resources for research, clinical practice and education; to strengthen research; to promote high ethical standards for practice and research; to assist in establishing guidelines for clinical practice; to develop collaborative relationships with other professional organizations; to emphasize the importance of the field of child abuse and neglect within medicine; and to honor individual physician's contributions to the physical and emotional health of victims of child abuse and neglect. The Helfer Society is interested in this and other cases which

affect a doctor's ability to evaluate a child's injuries and protect the child from child abuse.

Introduction

The crux of this case is an experienced pediatrician reasonably suspected an infant had suffered serious injuries at the hands of his parents and would be injured again if released to them. The baby was hospitalized for two days for his safety and further evaluation[1]. Hospitalization was in accord with medical ethics and best practices, but on appeal the majority found it constituted a "clearly established" violation of law. The majority opinion violates both Supreme Court and this court's precedents, and will have a chilling effect on the reporting of child abuse.

G.J. is a nonverbal infant who suffered both skull and rib fractures while with his parents, the Joneses. The story given by his mother was medically inconsistent with his injuries. Radiologists believed the injuries were indicative of child abuse, and medical literature confirmed that belief. Based on these findings, Dr. Claudia Wang—the medical director of the UCLA Suspected Child Abuse and Negligence Team, a pediatrician, professor, and expert in child abuse with over 20

[1] Dr. Wang recommend hospitalization and G.J.'s mother agreed. The majority found there is a factual dispute about whether the mother's consent was voluntary. However, amici believe irrespective of consent, Dr. Wang should have been granted summary judgment based on the undisputed medical evidence. First, G.J.'s hospitalization in this instance did not constitute an "unreasonable seizure" because hospitalization was supported by medical ethics and best practices in child abuse cases. Second, even if it was unreasonable, at a minimum, Dr. Wang is entitled to qualified immunity because there is no case which addresses a physician's role in this context.

years of experience—reasonably suspected G.J. had been abused by his parents and would be in danger if released. She made sure G.J.'s case was reported as suspected child abuse, and asked a social worker from the Los Angeles County Department of Children and Family Services to place a hold on G.J. Unfortunately, he did not issue an immediate hold.

G.J. was hospitalized for a weekend for his safety and accelerated additional testing to confirm or rule out child abuse. During his hospitalization, G.J. could be with his parents, had a sitter in his room and wore a tracking bracelet. On Monday, the social worker issued a hold.

This case is about G.J.'s two days in the hospital. The parents sued Dr. Wang, claiming Dr. Wang unreasonably seized G.J., and the district court denied Dr. Wang's motion for summary judgment based on the merits and immunity. A divided panel affirmed.

This case is disturbing for many reasons, perhaps the most important being it will negatively impact a physician's ability to treat, evaluate and protect vulnerable victims of child abuse. Amici agree the majority opinion is wrong for the reasons discussed in the dissent and Dr. Wang's petition for rehearing. 9th Cir. R. 29–1 Advisory Committee Note. Moreover, amici believe the majority opinion requires a doctor to violate medical ethics and best practices in child abuse cases, and will have a chilling effect on the reporting of those cases. The opinion's standard of

review for a denial of summary judgment in a child abuse case could require a trial in any case where a parent denies abuse. And it is unjust to hold anyone personally liable based on the opinion's overbroad definition of what constitutes a "seizure."

The majority opinion denied immunity to Dr. Wang even though no prior precedent of this court has ever addressed a physician's authority to hospitalize a child in a case of suspected child abuse. Rehearing en banc should be granted.

Undisputed Medical Evidence

Although the opinion, dissent and petition discuss the facts in general terms, a closer examination of the undisputed medical evidence shows the precise type of skull and rib fractures G.J. suffered indicate child abuse, and his mother's story does *not* explain all of his injuries.

Even without the rib fractures, G.J.'s skull fractures were enough to raise a reasonable suspicion of child abuse because he had multiple fractures that were: (1) complex (involving more than one cranial bone); (2) depressed; (3) wide; (4) diastatic (widening the sutures in the skull); (5) non-parietal (involving the occipital lobe as well as the parietal lobe); and (6) crossed suture lines. *See* ER 361 (Dr. Wang's decl.), 419-21 (G.J.'s medical records); SER 277-79 (Dr. Jerry Dwek's decl.: two non-continuous fractures of the skull, involving the right parietal bone and left side of the occipital bone, like G.J. had, are significantly associated with abuse), 1204-10 (C J Hobbs, *Skull Fracture and the Diagnosis of*

Abuse, 59 ARCHIVES OF DISEASE IN CHILDHOOD 246, 246 (1984) ("in skull fracture in young children, where a minor fall is alleged, it is possible to recognise [sic] abuse by consideration of the fracture alone")).

About a week later, a skeletal survey showed bilateral posterior rib fractures to G.J.'s sixth and seventh ribs which had not been seen on earlier X-rays taken of his chest. ER 233-34. Thus, he had symmetrical fractures to the ribs on his back. Dr. Wang and at least two pediatric radiologists—Drs. Ines Boechat, and Theodore Hall—all thought the injuries were consistent with child abuse. ER 3, 42, 76, 233-36, 304-06, 363-66, 379-80, 425. Rib fractures in an infant are extremely concerning for child abuse and can occur when an adult uses her hands to grab the infant under the arms and squeeze his chest. Ninety-five percent of rib fractures in infants are caused by abuse, especially posterior bilateral rib fractures like G.J. had. Katherine A. Barsness, MD, et al., *The Positive Predictive Value of Rib Fractures as an Indicator of Nonaccidental Trauma in Children,* 54 J. TRAUMA 1107, 1107-09 (2003), at ER 403-05; *see also* SER 239 (Dr. Cindy Christian's decl.: rib fractures in infants are strongly correlated with child abuse), 277 (Dr. Dwek's decl.: posterior rib fractures are highly specific for child abuse).

G.J.'s mother said all of his skull and rib injuries were the result of one accidental fall on the stairs. "Pts mother . . . thinks that the first thing that [G.J.'s] head hit was the crook of her arm as she hit the ground, and then he bounced out of

her arms and hit the floor." ER 430. But Dr. Wang concluded not all of G.J.'s injuries could have occurred under the scenario his mother described. ER 366-68. Pediatric expert Dr. Carole Jenny agreed:

> The explanation eventually given [but not until the Juvenile Court proceedings] for the fractures was that the mother squeezed the child's chest when she fell. But if she compressed the chest hard enough to cause fractures, it is hard to understand why the child flew out of her grip. In addition, she described the infants head as hitting the crook of her arm. It is again hard to understand how both sides of the rib cage would be squeezed with one arm if the head was on the mother's antecubital fossa.

SER 338. *Accord* Christine T. Chiaviello, MD, et al., *Stairway-Related Injuries in Children*, 94 J. PEDIATRICS 679, 679-80 (1994), at ER 414-15; SHARON P. DOUGLAS, MD, REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS 151 (2012), available at https://perma-archives.org/media/2014/4/6/19/25/UGE6-449V/cap.pdf (Physician Responsibilities for Safe Patient Discharge from Health Care Facilities Report).

All of G.J.'s injuries were inflicted while he was in his parents' custody. His parents never suggested otherwise. Thus, Dr. Wang had a reasonable suspicion G.J.'s injuries were caused by parental abuse, and she reasonably concluded she should conduct further tests to confirm or rule out such abuse. *See* ER 362, 369-70 (Dr. Wang's Decl.). Pediatric experts Drs. Cindy Christian (SER 231-63), Jerry Dwek (SER 274-304) and Carole Jenny (SER 327-83) all agreed with Dr. Wang's conclusion. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L CTR. FOR

INJURY PREVENTION & CONTROL, CHILD MALTREATMENT: FACTS AT A GLANCE (2014), available at http://www.cdc.gov/violenceprevention/pdf/childmaltreatment-facts-at-a-glance.pdf (80.3% of child abuse is caused by parents).

G.J.'s parents offered *no* medical evidence to support their claims.

Argument

Rehearing en banc should be granted because this case involves a question of exceptional importance and because it is necessary to maintain uniformity of decisions. FRAP 35(a). The majority opinion requires a doctor to violate medical ethics and best practices in child abuse cases. In addition, the opinion will have a chilling effect on the evaluation and reporting of child abuse. Further, the opinion conflicts with this court's precedent on the standard of review for a denial of summary judgment. Finally, it would be unjust for a jury to find anyone personally liable under the opinion's overbroad definition of "seizure."

I. The Majority Opinion Requires a Doctor to Violate Medical Ethics and Best Practices in Child Abuse Cases.

The majority points out the main reason G.J. was hospitalized for further evaluation and accelerated testing was because Dr. Wang suspected he had been abused and she "did not have a plan to discharge him safely to his home." Op. at 8. Although Dr. Wang had a reasonable suspicion G.J.'s skull and rib fractures were caused by abuse, she told the social worker, "she did not have a definitive diagnosis of child abuse and wanted time to conduct further tests. Dr. Wang also

stated she believed G.J. would be in danger if released." Op. at 9. To put it another way, under the majority opinion, even if a doctor reasonably suspects a child has suffered abuse resulting in serious bodily injury and would be in danger of continued abuse if released, the doctor *cannot* seek hospitalization for further testing to confirm or rule out abuse, or protect the child.

This contradicts medical ethics and best practices in child abuse cases.

A. Medical Ethics Only Permit Patient Discharge into a Safe Environment.

A doctor has an ethical duty to discharge a patient only into a safe environment. According to the American Medical Association, "Physicians' primary ethical obligation to promote the well-being of individual patients encompasses an obligation to collaborate in a *discharge plan that is safe for the patient*. As advocates for their patients, physicians should resist any discharge requests that are likely to compromise a patient's safety." *Opinion 9.141—Safe Patient Discharge*, AMERICAN MEDICAL ASSOCIATION, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9141.page (adopted June 2012) (italics added).

B. Best Practices Require Hospitalization If Necessary to Protect an Injured Child from Abuse.

Hospitalization is medically necessary if needed to evaluate or treat a child's injuries, or protect him from abuse. According to the American Academy of

Pediatrics (AAP), "[a]rranging hospitalization for a child who requires additional medical testing and/or *protection is often required*, allows for additional consultation and observation, and should be considered medically necessary . . . ." Cindy W. Christian, MD, et al., *The Evaluation of Suspected Child Physical Abuse*, 135 J. PEDIATRICS e1337, e1348 (2015), available at http://pediatrics.aappublications.org/content/135/5/e1337 (italics added). "*To protect children who are victims of physical abuse*, . . . [p]ediatricians may need to hospitalize children with suspicious injuries for medical evaluation, treatment, and/or protection." *Id.* at e1349 (italics added). "Pediatricians are in a unique position to recognize abuse and protect victims, especially young children, children with disabilities, and other children who are isolated in some way from regular contact with the public." *Id.* at e1347-48.

The majority's assertion its decision will not "prevent a physician from ordering medically necessary tests or procedures for a child" depends on the assumption it is not "medically necessary" for a doctor to arrange hospitalization to protect a child who is a suspected victim of abuse. Op. at 29-30, n.9. This assumption is belied by the contrary findings of the AAP. Christian et al., *supra*, at e1348.

In fact, the first guideline for managing child abuse at another well-known university hospital, Stanford University Hospital, is to "Hospitalize the Suspected

Case." STANFORD UNIVERSITY HOSPITAL, DEP'T OF CLINICAL SOCIAL WORK, DEP'T OF PEDIATRICS PROCEDURE, GUIDELINES FOR MANAGING CHILD ABUSE AND NEGLECT CASES AT STANFORD UNIVERSITY HOSPITAL 1, available at http://med.stanford.edu/gme/incoming_residents/documents/childAbuseReportingRequirements.pdf. Safeguarding the child is the most important consideration for hospitalization: "The purpose of hospitalization is to protect the child until other evaluations regarding the safety of the home are complete. The extent of injuries is not relevant to this requirement. [¶] *The child's need for protection supersedes any other consideration*." *Id*. (italics added).

Other circuits have held hospitalization and seizure of a child for his safety is not unreasonable where there is a reasonable suspicion of abuse or an investigation of abuse is pending. *Thomason v. SCAN Volunteer Servs., Inc.*, 85 F.3d 1365, 1373 (8th Cir. 1996) (affirming summary judgment: "Where a treating physician has clearly expressed his or her reasonable suspicion that life-threatening abuse is occurring in the home, the interest of the child (as shared by the state as parens patriae) in being removed from that home setting to a safe and neutral environment outweighs the parents' private interest in familial integrity as a matter of law."); *Kia P. v. McIntyre*, 235 F.3d 749, 759 (2d Cir. 2000) (affirming summary judgment in favor of a hospital and finding its seizure of an infant was

not unreasonable even "*after* the primary evidence of abuse had been discredited" because hospitalization of the baby pending the welfare agency's deliberative process on whether to issue a hold "is a reasonable accommodation of the state's compelling interest in protecting children from abuse and neglect."); *Gottlieb v. Cnty. of Orange*, 84 F.3d 511, 518 (2d Cir. 1996) (affirming summary judgment: "Where, however, there is an objectively reasonable basis for believing that parental custody constitutes a threat to the child's health or safety, government officials may remove a child from his or her parents' custody at least pending investigation.").

Since medical ethics and best practices require hospitalization, hospitalization cannot constitute an "unreasonable" seizure in this context. Moreover, even if hospitalization were unreasonable on these facts, Dr. Wang had no way of knowing her attempt to protect the best interests of a child in her care would be deemed a constitutional violation. G.J. was an 11-week-old infant with skull and rib fractures which Dr. Wang reasonably suspected were the result of abuse from his caregiver parents. ER 366-68. She hospitalized G.J. to protect him and further evaluate his injuries until she had a safe discharge plan. *Id.* It would not be "obvious to a reasonable officer" that complying with medical ethics and best practices in child abuse cases would be unlawful, and this court has never before dealt with the scope of a physician's authority in this context. *Sjurset v.*

Button, 2015 WL 7873404, at *10 (9th Cir. Dec. 4, 2015). "[T]he 'contours' of the Fourteenth and Fourth Amendment rights at issue were not clearly established in this context." *Id*. (finding qualified immunity applied where officers were in a catch-22 situation: either potentially endanger children's safety by ignoring a social worker's order to remove the children, or risk being sued for violating the children's and parents' constitutional rights by carrying out the order). So at a minimum, Dr. Wang was entitled to qualified immunity.

II. The Majority Opinion Will Have a Chilling Effect on the Evaluation and Reporting of Child Abuse.

"Society has seen fit to qualify parental rights in certain circumstances in favor of the life and liberty rights of a child." *Mueller v. Auker*, 700 F.3d 1180, 1195 (9th Cir. 2012) (affirming summary judgment based on qualified immunity for temporary removal of a sick infant from parents' custody for testing and treatment recommended by physicians).

But under the majority opinion, even if a doctor reasonably suspects a child has suffered a serious bodily injury from abuse and would be in danger if released, the doctor *cannot* seek hospitalization for further testing to confirm or rule out abuse.

This will have a chilling effect on the evaluation and reporting of child abuse. As the dissent explained, "I share Judge Kozinski's concern that 'future babies will pay with their lives' due to the current trajectory of our qualified

immunity case law.'" Op. at 39 (McNamee, J., dissenting) (quoting *Kirkpatrick v. Cnty. of Washoe*, 792 F.3d 1184, 1203 (9th Cir. 2015) (Kozinski, J., dissenting) (petition for reh'g en banc filed)).

A. Child Abuse Is Already Underreported.

Most child abuse cases are never reported. "In one major study sponsored by the CDC [Centers for Disease Control and Prevention], 25% of adults reported having been victims of physical and/or emotional abuse as a child, [and] 28% said they had been physically abused . . . ." *Breaking the Silence on Child Abuse: Protection, Prevention, Detection and Deterrence Hearing Before Sen. Health, Educ., Labor and Pensions Comm.*, 112th Cong. 4 (Dec. 13, 2011) (testimony of Robert W. Block, MD, FAAP, American Academy of Pediatrics), available at http://www.help.senate.gov/imo/media/doc/Block.pdf ("Block Testimony"). The CDC found "reports of child maltreatment may underestimate the true occurrence." CTRS. FOR DISEASE CONTROL & PREVENTION, *supra*, available at http://www.cdc.gov/violenceprevention/pdf/childmaltreatment-facts-at-a-glance.pdf.

B. Many Doctors Do Not Report or Consult on Child Abuse Cases for Fear of Being Sued by the Family.

A study conducted by the AAP found many pediatricians are not reporting all suspected cases of child abuse and neglect because, among other things, the pediatricians "[f]ear legal retribution from families." Block Testimony, *supra*, at 11. A study conducted by the United States Department of Health and Human

Services (DHHS) found 9% of pediatricians surveyed by the AAP "declined to consult on an abuse/neglect case in the past year." U.S. DEP'T OF HEALTH AND HUMAN SERVS., REPORT TO CONGRESS ON IMMUNITY FROM PROSECUTION FOR PROFESSIONAL CONSULTATION IN SUSPECTED AND KNOWN INSTANCES OF CHILD ABUSE AND NEGLECT 5 (June 2013), available at http://www.acf.hhs.gov/sites/default/files/cb/capta_immunity_rptcongress.pdf. When asked why they may decline to assist in a child abuse investigation, pediatricians' responses included they worry about "being the subject of a lawsuit"; "they had prior negative experiences with lawsuits"; "hiring an attorney is expensive"; and they "were concerned about their malpractice rates going up." *Id*. at 5-6.

C. Even an Unsuccessful Lawsuit Impacts a Doctor's Future Availability to Evaluate and Report Child Abuse.

Pediatricians' concerns about being sued are well founded even if the lawsuits themselves are not, and irrespective of outcome, litigation takes a toll. Five percent of the pediatricians surveyed by the AAP had been sued in federal court, and six percent in state court. *Id* at 6. "Negative consequences resulting from being named in either a federal or state lawsuit are anxiety/depression or emotional stress; time taken away from practice; financial burden on themselves or their institutions; and the repercussions of a negative reputation. Eight percent reported the outcome of a lawsuit impacted their willingness to consult/assist on cases in the future . . . ." *Id*.

D. A Broad Interpretation of Immunity Is Necessary to Encourage Doctors to Consult on Child Abuse Cases.

When asked what would increase the likelihood of future participation in child abuse cases, pediatricians' recommendations included strengthening immunity and "increasing attorney/judge knowledge about medical aspects of child abuse/neglect." *Id*. at 7.

In fact, the DHHS recommended strengthening immunity from liability for physicians and other professionals who consult in child abuse and neglect cases to facilitate evaluation and reporting. *Id*. at 20. The DHHS concluded, "A critical issue is providing stronger protection to allow professionals to work on child maltreatment cases without fear of being sued for providing assistance to vulnerable children." *Id*.

Amici are not asking the Ninth Circuit to judicially legislate. Amici's point is if Congress is recommending strengthening immunity for physicians across the country, then at a minimum the Ninth Circuit should give existing immunity broad interpretation and interpret qualified immunity consistent with Supreme Court precedent. *Ashcroft v. al-Kidd,* 131 S.Ct. 2074, 2085 (2011) ("[w]hen properly applied, [qualified immunity] protects 'all but the plainly incompetent or those who knowingly violate the law.'") (quoting *Malley v. Briggs,* 475 U.S. 335, 341 (1986)).

Amici understand there may be times when a physician gets it wrong and inadvertently creates a hardship for parents. But when a physician is assessing an injured child for suspected abuse by his parents, there should be a presumption of reasonable suspicion of imminent harm. Without the physician's protection, a vulnerable infant might be defenseless and face further abuse. Moreover, even if a presumption does not apply, if the physician is acting competently and in good faith, then at a minimum qualified immunity should apply.

In this case, Dr. Wang reasonably suspected G.J. had suffered abuse at the hands of his caregiver parents. ER 366-68. During her evaluation, she hospitalized G.J. so she could keep him safe. *Id*. Her conduct was exemplary. The majority's holding Dr. Wang is not entitled to immunity will have a chilling effect on the evaluation and reporting of child abuse in the future. Doctors are already avoiding consulting on these cases for fear of family retribution through litigation; the majority's narrow interpretation of immunity will only increase that fear.

III. The Majority Opinion Conflicts with This Court's Precedent on the Standard of Review of a Denial of Summary Judgment.

Throughout its opinion, the majority repeatedly relied on the parents' version of the facts. Op. at 16, 19, 21, 28. The majority made the mistake of relying on the *allegations* in the parents' complaint as if this were a motion to dismiss the complaint (Op. at 15), instead of relying on *evidence* presented in

opposition to the summary judgment motion. *Compare* Fed. R. Civ. P. 12(b)(6) & (d) *with* 56(c) & (e). And the majority relied on the parents' version exclusively, without regard to the undisputed evidence, expert testimony and medical literature to the contrary.

This flies in the face of this court's standard of review for a denial of summary judgment. This court has held "if a defendant moving for summary judgment has produced enough evidence to require the plaintiff to go beyond his or her pleadings, *the plaintiff must counter by producing evidence of his or her own*. . . . Similarly, if in that circumstance the plaintiff produces evidence that is not enough, by itself, to create a genuine issue of material fact, the district court is not required (or even allowed) to assume the truth of challenged allegations in the complaint in order to supplement the evidence." *Butler v. San Diego Dist. Attorney's Office*, 370 F.3d 956, 963 (9th Cir. 2004) (italics added) (vacating partial denial of summary judgment motion based on immunity); *see also KRL v. Moore*, 384 F.3d 1105, 1110 (9th Cir. 2004) (reversing in part denial of summary judgment motion based on immunity).

Here, as pointed out in the petition for rehearing, the evidence of exigent circumstances was undisputed. PFREB at 6-7. Dr. Wang established by undisputed medical evidence, literature and expert testimony she had a reasonable suspicion to believe G.J. was in danger of harm if released to his parents. The

parents failed to sufficiently dispute that evidence and offered *no* medical evidence to support their claims. The majority's analysis conflicts with this court's precedent on the standard of review for a denial for summary judgment, and could require a trial in any case where a parent denies abuse.

IV. It Is Unjust to Hold Anyone Personally Liable Based on the Majority Opinion's Overbroad Definition of "Seizure."

Personal liability for a seizure should only be based on acts that individual is directly responsible for. The majority's definition of "seizure" is overly broad.

As the dissent points out, "the majority cobbles together multiple facts spanning over three days to find that Dr. Wang seized G.J. However, as noted in the opinion, '[a] seizure is a single act, and not a continuous fact.'" Op. at 33 (McNamee, J., dissenting) (quoting *California v. Hodari D.*, 499 U.S. 621, 625 (1991)).

Moreover, the majority based the seizure on multiple acts, including some performed by people other than Dr. Wang. Op. at 7-10, 16-18. Most obviously, the majority relies on the fact the social worker threatened the parents with possibly removing G.J. from their custody to get them to consent to G.J.'s hospitalization. Op. at 10, 17-18. But Dr. Wang was not present when the social worker threatened the parents nor was she with the parents most of the time during the days which the majority found constituted a seizure. Dr. Wang did not perform, direct or necessarily know of all the acts which the majority relied on.

And in fact, the parents never asked Dr. Wang if they could take G.J. home from the hospital. So how could Dr. Wang know how much pressure was being applied on the parents to stay or how it was being applied?

The majority's definition of "seizure" is so broad it is unworkable in the context of personal liability. Not only is it contrary to Supreme Court law to have a seizure defined by multiple acts over many days, but it is also unreasonable to hold one person responsible for all those acts unless she was present the entire time and performed or directed the acts herself.

Conclusion

For the reasons discussed above, amici support the petition for rehearing en banc and panel rehearing.

Respectfully submitted,

s/ Audra Ibarra

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Certificate of Compliance

I certify this brief complies with the type-volume limitation set forth in the Federal Rules of Appellate Procedure. This brief uses a proportional typeface and 14-point font, and contains 4,200 words or fewer. FRAP 29(c)(7); 9th Cir. R. 29–2(c)(2). This brief was prepared using Microsoft Word.

Respectfully submitted,

s/ Audra Ibarra

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9th Circuit Case Number(s) 12-55995

NOTE: To secure your input, you should print the filled-in form to PDF (File > Print > *PDF Printer/Creator*).

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CERTIFICATE OF SERVICE
When All Case Participants are Registered for the Appellate CM/ECF System

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on (date) 12-14-2015 .

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Signature (use "s/" format) s/ Audra Ibarra

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CERTIFICATE OF SERVICE
When Not All Case Participants are Registered for the Appellate CM/ECF System

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on (date) .

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. I have mailed the foregoing document by First-Class Mail, postage prepaid, or have dispatched it to a third party commercial carrier for delivery within 3 calendar days to the following non-CM/ECF participants:

Signature (use "s/" format)